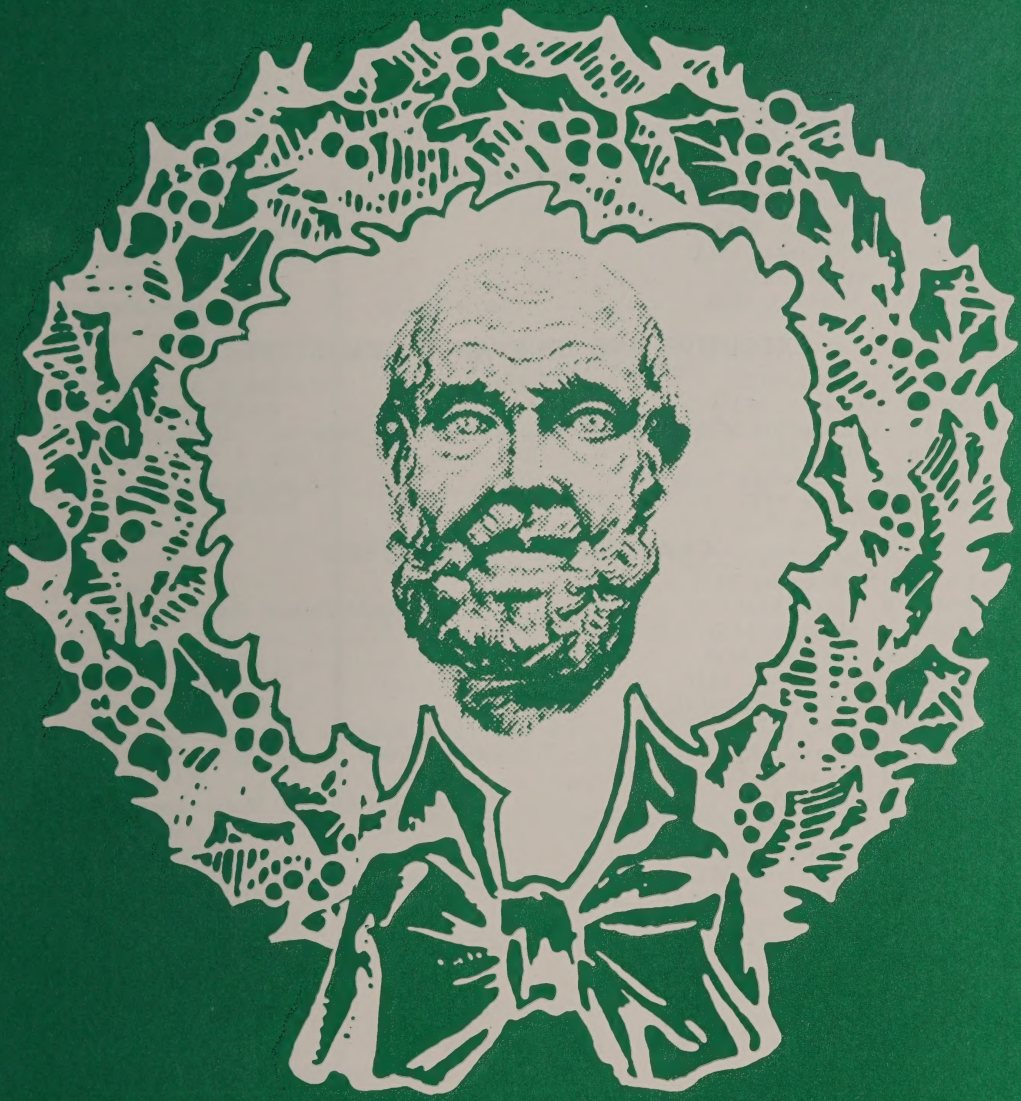

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THE HAMPDEN HIPPOCRAT
·1942·

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EDITORIAL

"TO BE, OR NOT TO BE"

Recent actions on abortion in this country caught many physicians off balance resulting in an undignified and unenlightening scramble for establishing a position. In the background lurks another ethical problem which may be sprung out suddenly from under the carpet where it has been lying but not too dormantly, namely, *euthanasia.*

Recently in England, the subject came under serious debate in the House of Lords where the Voluntary Euthanasia bill was considered and rejected by a narrow margin. Subsequently, the subject was discussed by a distinguished panel of the Royal Society of Medicine and published in the *Proceedings of the Royal Society of Medicine* (63:539-670, 1970). Lord Platt, a former president of the Royal College of Physicians, pointed out that there were occasions when in his opinion euthanasia was justifiable, humane, and ethical. These instances required only negative, or at most, indirect action on the part of the physician; i.e. turning off the apparatus, instituting pain relieving medical or surgical palliative measures which would tend to shorten a patient's life, and not interfering with a terminal patient's own efforts to hasten the inevitable. Moreover, such is indeed a common occurrence with no culpability being ascribed thereto. Voluntary euthanasia would only be going one step further, wherein legal provision would be made for allowing a physician to accelerate a patient's death at the latter's request.

The concept of euthanasia raises many enigmatic points. To many physicians, euthanasia is synonymous with murder. The commandment "thou shalt not kill" has not as yet been repealed. To sons of Hippocrates, killing has been and still is an uncompromising ethical "no, no". Moreover, should euthanasia under any circumstance be legalized, where could and would any line be drawn? To quote William Lamb, Lord Milbourne (1779-1848): "If they get the habit of doing such a thing when a person is in a hopeless state, why, they may do it when a person is not in a hopeless state." The confidence of every patient in his physician would be undermined. Furthermore, political, social, and economical influences might lead physicians to accept as ethical such practices under the guise of legal euthanasia as controlling the population explosion with its related problems and going to such extremes as occurred in Nazi Germany.

The concept of "voluntary euthanasia" has been advanced by the apparently increasing acceptability of intervention in the name of "dying with dignity". The latter concept is succinctly put by Wilder Penfield in his book entitled *The Second Career.* "There are times when compassion should prompt us to forego prolonged and costly treatment. If a man must die, he has the right to die in peace as he would prefer to do if asked. Positive action to take a life is not permitted. But the negative decisions that ease and shorten suffering have always been ours to make." Proponents of voluntary euthanasia would add positive action on demand by the patient to accelerate death in the name of mercy and under the rationale of sympathy and best interest of the patient. Some legal authorities claim that such an appropriate change in the law would not compel physicians to do anything. It would only protect them from prosecution if they accelerated death under prompting of humane feelings and acting in good faith

for the patient's benefit. Perhaps, there are physicians with greater insight who can acknowledge the positive acceleration of death and justify same to themselves in terms of human needs, desires, and rights.

The subject of euthanasia will not remain submerged; it is bound to come to the surface in public debate and even action just as did the matter of abortion. We, physicians, will be inexorably and deeply involved; hence, we must discuss, become informed, and arrive possibly at some understandings. Former Chief Justice Earl Warren once said: "In civilized life, law floats in a sea of ethics." Can our ethics be reconciled with legislated euthanasia in any form or degree?

Ayres

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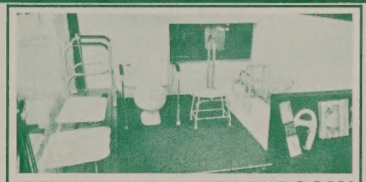

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PHYSICIAN-CLERGY COOPERATION

by

GARY deN. HOUGH, M.D.
CHAIRMAN, MMS COMMITTEE ON MEDICINE AND RELIGION

There is increasing condemnation of the medical profession for the fragmentary care of the patient brought on by medical specialization. The need for specialization is well known to all of us, but less obvious to the public. Even when physicians are able to overcome the specialty approach and treat illness in many systems, it is still difficult to consider the patient's needs in a truly holistic fashion. Most physicians are aware of the inter-play between social and spiritual health and physical well-being. However, few of us act as if we attached very much importance to it.

Inasmuch as the clergy are entrusted with the spiritual well-being of their congregations, it would appear that holistic medicine would be enhanced by physician-clergy cooperation. Some clergymen who are trained in pastoral counseling are also capable of interpreting the patient's social well-being and can be of even more assistance to the physician. At the present time only about 15 per cent of clergymen are receiving this education. Men so trained may be fulfilling any clerical roll, but are frequently found functioning as hospital chaplains.

Another current trend is the emphasis on delegation of medical activity to paramedical personnel. I feel that the medical profession has overlooked the paramedical value of properly trained clergy. The physician has tended to characterize the clergy as meddlesome, unrealistic, and ineffective. Conversely, many of the clergy consider physicians materialistic, technically oriented, selfish, and non-obligated. More contact between the two groups will replace these attitudes and establish the level of mutual trust necessary to form professional relationships. Divergence in philosophy among physicians, clergy, and patients make sweeping generalizations dangerous but tend to block continuing programs. However, individual physicians can cultivate individual clergymen of similar persuasion to form a more effective treatment team.

With increasing emphasis on hospital based medicine, the roll of the hospital chaplain as a paramedical asset increases. It is important for physicians to familiarize themselves with the chaplaincy program in their own hospitals and to use the chaplain's services for the benefit of their patient. For those interested in wider horizons there are increasing opportunities for cooperation at the graduate and post graduate level for improving the ability of both physician and clergy to treat the patient as a whole. Whether you wish to learn, teach, or merely communicate, there is much to be done.

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President's Page

RELIGION AND MEDICINE

Modern members of the clergy and physicians are heirs to a tradition of joint concern for man's destiny. In pursuit of high goals both for the spiritual aspects of life and for physical well being, objectives sometimes overlap. It has been said that the body is the temple of the soul. It is inspiring and challenging to clergymen and to physicians alike to attempt attainment of the best qualities of life for all who rely upon them.

Our present sharing of concern for patients involves representatives of the Jewish, Greek Orthodox, Catholic, and Protestant faiths in hospital and in home visitations and in counselling. This generation of clergymen has generally an increased appreciation of scientific methodology. Many are interested in psychology and many have a much greater understanding of health and disease than had their predecessors. Mutual problems of drugs, sex education, family planning and health legislation have increased the interchange between religion and medicine to the great advantage of both disciplines.

As we look toward the future, let us work at continuing cooperation with the clergy. Increased exchange of information is to be desired. Joint efforts to sort out the best of changing concepts of abortion, euthanasia and other problems will be needed both in HDMS and beyond.

John W. Turner

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ABORTION: THERAPY OR CONVENIENCE?

Therapeutic abortion is defined in Eastman's textbook as the instrumental termination of pregnancy because of some grievous internal disease which would cause the continuation of pregnancy to be hazardous. The present standards followed by most physicians are state laws, the AMA policy of 1970, the American College of Obstetricians and Gynecologists' policy of 1970 and conservatism in most quarters.

The general laws of the Commonwealth of Massachusetts, Chapter 272, entitled "Crimes Against Chastity, Morality, Decency, and Good Order," Section 19, read as follows: "Whoever with intent to procure the miscarriage of a woman, unlawfully administers to her or advises or prescribes for her or causes any poison, drug, medicine or other noxious thing to be taken by her or with the like intent unlawfully uses any instrument or other means whatever or with like intent aids or assists therein shall, if she dies in consequence thereof, be punished by imprisonment in the State Prison for not less than 5 nor more than 20 years; and, if she does not die in consequence thereof, by imprisonment in the State Prison for not more than 7 years and by a fine of not more than $2,000.00." Termination of pregnancy by medical abortion is apparently legal under certain circumstances. The use of the words "unlawfully" and "unlawful" as applied to abortions in the above statutes implies that there is such a thing as lawful abortion, and physicians have long considered therapeutic abortion lawful under certain circumstances. The interpretation of the law has been approved by the Mass. Supreme Judicial Court in 1961 in the case of the Commonwealth vs. Brunelle in which the Court said and we quote, "We have held that a physician is justified in affecting an abortion where he has exercised his skill and judgment in the honest belief that his acts were necessary to save the woman from great peril to her life or health."

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Other cases which have a bearing in Mass. are as follows: In the Commonwealth vs. Brown, abortion was upheld provided that the physician's judgment corresponds with the average judgment of the doctors in the community in which he practices. In the case of the Commonwealth vs. Wheeler, the Court stated for the purpose of this case at least we may assume that in general a physician may lawfully procure the abortion of a patient if in good faith he believes it to be necessary to save her life or to prevent serious impairment of her health, mental or physical, and if his judgment corresponds with the general opinion of competent practitioners in the community in which he practices. It should also be observed that the Court permitted evidence to be introduced in the Wheeler Case that good medical practice requires that therapeutic abortions be performed in a hospital and not in an office and only after previous professional consultation with other physicians, although the Court did not specifically require this practice be followed. One fact is very clear, namely that therapeutic abortions be performed in hospitals with high standings throughout Mass. after medical consultations, thus demonstrating an established belief on the part of physicians that such operations are lawful in view of the implications of the statutes and the available judicial interpretations.

In the past years, many states have modified their abortion laws along the lines recommended by the American Law Institute. These states are Arkansas in 1969, California in 1967, Colorado in 1967, Delaware in 1968, Georgia in 1968, Kansas in 1969, Maryland in 1968, New Mexico in 1969, North Carolina in 1967, Oregon in 1969, New York in 1970. In addition, Mississippi modified its statute in 1966 to permit abortions in case of rape or incest. Hawaii was the first state to enact an "abortion on demand" law requiring only that the fetus or embryo be non-viable and that the procedure be performed by a licensed physician in a licensed hospital upon a woman who has lived in Hawaii for at least 90 days.

The American College of Obstetricians and Gynecologists adopted a policy on August of 1970 based on the following principles. Policies covering abortions should be designed by the medical staff to safeguard the patient's health or improve her family life situation. They should have due regard for local legal statutes and judicial decrees. Abortion should only be performed in facilities that are administered by a hospital accredited by the Joint Commission on Accreditation of Hospitals and/or licensed by a state or province. It is recognized that abortion may be performed at a patient's request or upon a physician's recommendation. No physician should be required to perform; nor should any patient be forced to accept an abortion. When abortion is requested by a patient, the request should be obtained in writing from the patient or

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in the case of a minor from her parent or guardian. The patient should be informed of the medical nature of the procedure and of its potential consequences. When abortion is recommended by a physician, the indication should be stated in the patient's record and informed consent obtained from the patient and her husband or herself, if she is unmarried, or from her nearest relative or guardian if she is under the age of consent. When abortion is requested by a patient, consultation is not necessary. When abortion is recommended by a physician, indication for the procedure should be approved by a consultant knowledgeable in regard to the condition thought to indicate abortion. Abortion is an operative procedure and should only be performed (1) by a physician who has hospital privileges for the care of obstetric and gynecological patients and (2) in a hospital facility adequately equipped to care properly for unexpected complications. In order to assure that adequate facilities will be available for indicated care of other obstetric-gynecological patients in some communities, consideration should be given by hospitals to (1) providing a room or entirely separate facilities where abortion can be performed with minimal disruption of other hospital activities and (2) utilizing hospital personnel who volunteer to care for patients admitted to be aborted.

The official AMA position is described as a position substantially liberalized and making abortion essentialiy a private relationship between the patient and her physician. It further states that social and economic conditions are to be considered in determining whether abortion is in the best of medical interest of the patient.

ETHICAL CONFLICT

It would seem that the legality of therapeutic abortion has been settled and within a very short time most of the states will have so-called liberalized abortion laws. With the solving of the legal conflict, we are now left with a great problem – that of the ethical conflict. It is highly unlikely that the ethical conflict will ever be solved by the legislators, and it is highly unlikely that there will be much compromise on either side. The

opponents of therapeutic abortion state that the new laws permitting abortion on demand are imposing ominous moral and social challenges. This group feels that the basic question is whether the practice of medicine can avoid being driven from utmost respect for human life from the time of conception to nethermost respect or to no respect at all for natent life until that moment when the woman decides to make it a member of the human community and to bestow upon it the status of childhood and personhood by expelling it from her body. They also feel that the public should sense the moral incongruity of a society that would turn the practice of medicine and nursing from an instrument for saving life into an instrument for destroying life for social indications, population control, genetic selection or last ditch contraception. These physicians state that one cannot arbitrarily have it both ways. To them, abortion on demand is an arbitrary assault upon the fetus as if it were nothing or simply a state of affairs of the mother needing remedy. Where this group stands on therapeutic abortion for medical reasons is not quite clear. If one were to argue against abortion for religious reasons, there could be no abortion for medical reasons.

Abortion on demand also raises another problem – that of the spector of malpractice. If abortion becomes increasingly a matter of customary medical practice, then independent medical judgment refusing an abortion in the face of a malpractice suit may have to take shelter behind a physician's plea of conscientious objection. This would then remove from the physician the distinction between abortion on demand for social reasons or therapeutic abortion for medical reasons. General objection to all abortion would then become the only shelter for selective abortion refusals on the part of physicians as conscientious objectors.

Of further concern to many physicians is the problem that if the decision for abortion is solely that of the patient, the physician then becomes little more than a technician performing a manual function. If the physician is released from the obligation of counseling and advising the patient, then it will not be long before we will be considering the ethical propriety of entrusting abortions to non-physician technicians.

The proponents of abortion have adopted the view of "let's stop passing the buck and manage the problem at hand." Abortion is no longer considered a moral or immoral issue nor a legal or illegal issue, but a problem which demands new concepts which will enable the distraught female to cope with the mental encumbrances imposed by present day culture. They propose the following outline:

(1) Empathic physicians who will perform abortion on request, not on demand.

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(2) Referral to psychiatrists if the patient is ambivalent concerning termination of pregnancy.

(3) No pregnancy terminations after 20 weeks gestation.

(4) Performance of all therapeutic abortions within the confines of an accredited hospital that offers both inpatient and outpatient facilities for termination of pregnancy by a licensed physician.

(5) Facilities for performing curettements as weekend admissions when bed availability is at its maximum.

(6) Social services to be used as a source of guidance not only for the distraught female, but for fetal fathers who feel a responsibility for this problem.

(7) Contraceptive counseling and follow-up under the auspices of either the gynecologist, psychiatrist or social worker or planned parenthood counselors.

(8) Programs to provide information concerning availability of abortions and financial assistance to eliminate discrimination against the poor.

Finally, individual state residency requirements for therapeutic abortions should be abolished so that patients can obtain termination of their pregnancies within the first trimester and are not placed into a higher risk category by performance of an abortion beyond this period. This group feels very strongly that pregnancy termination programs must be ethical and efficacious, and its guidelines should be established by the medical profession or the medical profession will have failed to evaluate the pulse and demands of society.

It must be made clear that we, as physicians, regardless of where we ethically stand should be well aware of the fact that liberalized abortion laws will not eliminate complications and mortality from induced abortions. Death can be caused by physicians! It is becoming increasingly clear that mortality rate from therapeutic abortions is now twice that for normal term pregnancies. The perforation rate is over 1% and 1/3 of these women must undergo a hysterectomy. Other early complications are hemorrhage, sepsis, Rh immunization, renal failure, and psychiatric sequelae. Delayed complications are chronic inflammatory pelvic disease, infertility, prematurity in subsequent pregnancy, Rh immunization, uterine perforation, ectopic pregnancies, endometriosis, and delayed psychiatric sequelae. The experience in Hungary has shown that the prematurity rate has increased from 10% to 24% after 2 or 3 induced abortions.

In the not too distant future, the problem of abortion or unwanted pregnancy may take a new twist. After a woman misses her period and decides that she does not want a child, she casually goes to her physician; he gives her a lactose vaginal suppository containing prostaglandin E or F. Four hours later she is given another suppository. In 2 to 7 hours after the second intravaginal treatment, menstruation begins the end of the patient's crisis. This hindsight contraception will very likely replace the need for therapeutic abortion and place the problem back into the conscience of the patient and the conscience of the physician. A decision will be made between the two individuals without the necessity of third parties such as hospitals, legislators, etc., being involved. Whether this is a step forward or a step backward, only time will tell.

Zadworny

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ETHICS AND ABORTIONS

"Therapeutic abortions now outnumber all other surgical procedures for women."

—A. J. Margolis, M.D.
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During the last decade or so *The Hippocrat* has been devoting routinely a portion of its December issues to a consideration of medical ethics.

At no time, as we recall, was there ever a paucity of pertinent material. For one thing the subject of ethics is so vast and complex as to fill volumes. In fact, this is exactly what our philosophers have been doing for ages, and the end is nowhere in sight. More important, however, is the fact that escalating biomedical advances have escalated also moral and ethical problems. Hippocrates never dreamed that a time might come when the physician (and society as well) would be called upon to ponder the ethical conduct involved in organ transplantation, birth control, artificial insemination, genetic control, hemodialysis, etc.

1970, THE YEAR OF ABORTION

Until not very long ago abortion was considered criminal and unethical throughout the civilized world. Hippocrates was explicit enough when he stated in his "Oath" that " . . . I will not aid a woman to procure abortion." The theologians took a similar and even sterner view. Finally, strict anti-abortion laws were to be found on the statute books of practically every nation and sovereignty.

To say that the abortion picture has changed drastically of late, would be a gross understatement. Communist Russia at first made abortion as free as air then changed its mind, ostensibly because of a precipitous drop in the birth rate. In 1956, however, abortion again became legal in Russia except that now the

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patient has to pay for it. England and the Scandinavian countries, as we all know, have let the abortion bars down considerably during the last 5 or 10 years.

What interests us chiefly, needless to say, is our own United States, and here we find that in the last 3 years 15 states have liberalized significantly their abortion laws. Most striking, however, is the fact that in the last year or two, three states have eliminated virtually all barriers. One of these is New York (the others are Alaska and Hawaii), where as recently as several months ago it was illegal to induce abortion and ipso facto also unethical. Now that all the legal roadblocks have been removed, what do we find? Aside from theologic and religious considerations our colleagues are today confronted with new problems and with new threats to the ethics of our profession.

First, there is the "abortion on demand" principle stipulated in the New York law, according to which the physician is obligated to terminate pregnancy whether or not it meets with his professional or moral approval. We need hardly be reminded that it is unethical for a physician to perform any act that violates his good judgment. Just imagine your reaction to a patient's *demand* for an appendectomy or even "a shot of penicillin." It is obvious that the New York legislators utilized little or no medical guidance in framing this portion of the new abortion act.

"GIVE US YOUR ABORTIONS, PLEASE"

Another shocking abuse of the new abortion laws is the solicitation of referrals.

"Dear Doctor:" begins one piece of promotional mail, this one from a hospital in New York, "We would like to take this opportunity to inform you that it is now the policy of this hospital group to permit terminations of pregnancy procedures pursuant to the recently enacted New York legislation." Price, including physician's fee, $575.00. Another "Dear Doctor" letter, this time from a physician in California, offers the same service for much less, namely $463.00. These are but two examples of the barrage of offending advertising to which our profession has been subjected from coast to coast. Never before has the AMA office received so many expressions of chagrin and resentment. Most of the outrage concerned the fact that the solicitations were sent far beyond the borders of the communities where the offenders lived and practiced.

Advertising and solicitation are as unethical for D&C's as they are for T&A's or appendectomies. In this respect the new abortion laws have created no new ethical problems. They have only created temptation for a few physicians and hospitals to capitalize on the situation. The AMA's Judicial Council has labeled these activities as "commercialization and hucksterism." The Council continues:

"The ethical principle remains: No physician may solicit patients. A physician may not do indirectly that which he may not do directly. He may not permit others to solicit patients for him."

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THE AMA AND ABORTION

At the AMA's Convention of last June the Reference Committee dealing with the question of abortion submitted a resolution consisting of three parts, only two of which were adopted by the House of Delegates (see below). Most significant, perhaps was the third part, the part that was rejected by the House. It reads as follows:

> "3. Resolved, that the American Medical Association will consider no physican to be in violation of the policies of the AMA as long as his practice conforms to the applicable state or federal laws."

The delegates voted against this portion of the resolution obviously because they felt that the AMA's abortion policy should be formulated not by the various state legislatures but by the AMA itself. The recently enacted New York law with its provision for "abortion on demand" attests to the wisdom of the AMA's decision and action of last June.

We now come to the Resolution on Abortion as adopted, after much debate and discussion, by the AMA's House of Delegates at the convention of June 25, 1970:

Whereas, Abortion, like any other medical procedure, should not be performed when contrary to the best interests of the patient since good medical practice requires due consideration for the patient's demands; and Whereas, the standards of sound clinical judgment, which, together with informed consent should be determinative according to the merits of each individual case; therefore be it

Resolved, That abortion is a medical procedure and should be performed only be a duly licensed physician and surgeon in an accredited hospital acting only after consultation with two other physicians chosen because of their professional competency and in conformance with standards of good medical practice and the Medical Practice Act of his State; and be it further

Resolved, That no physician or other professional personnel shall be compelled to perform any act which violates his good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional personnel withdraw from the case so long as the withdrawal is consistent with good medical practice."

THE MMS AND ABORTION

At the Council meeting of October 14, 1970 the Committee on National and State Legislation recommended the adoption of the AMA's Resolution on Abortion, (see above). The Council, however, voted to table the Committee's recommendation. (For a fuller description, see *The Hippocrat,* Nov. 1970).

Whether or not abortion laws will ever undergo drastic changes on Beacon Hill is difficult to predict. A bill to abolish Massachusetts anti-abortion laws and to allow abortions on request was filed on December 1, 1970. If and when such legislative changes do take place, Our Society will want to make sure that they will not jeopardize in any way the principles and ethics of our profession. Our Society will also want to make sure that none of our members will exploit these possible changes to the detriment of the health and welfare of the public.

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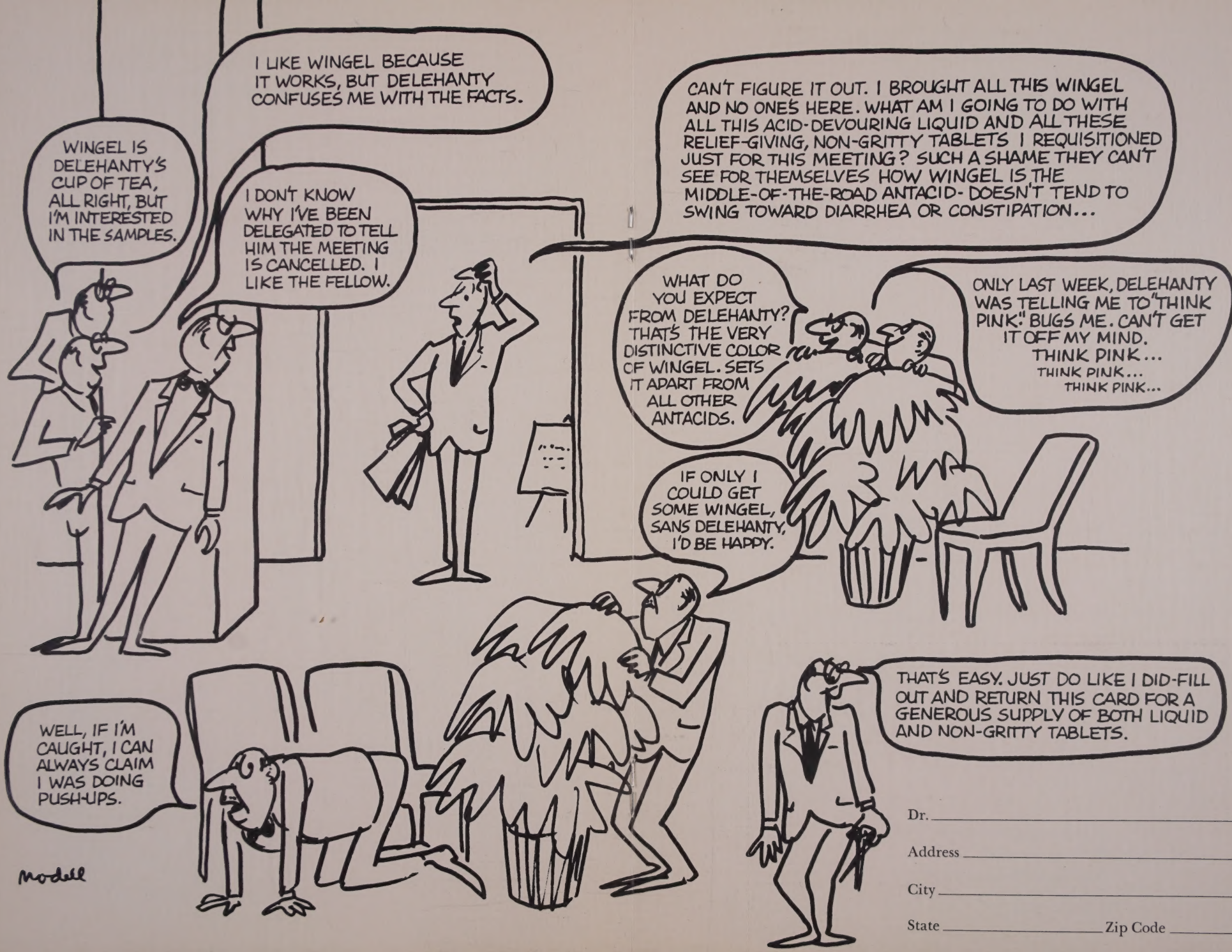
J. RODERICK DELEHANTY AT THE COUNTY MEDICAL SOCIETY

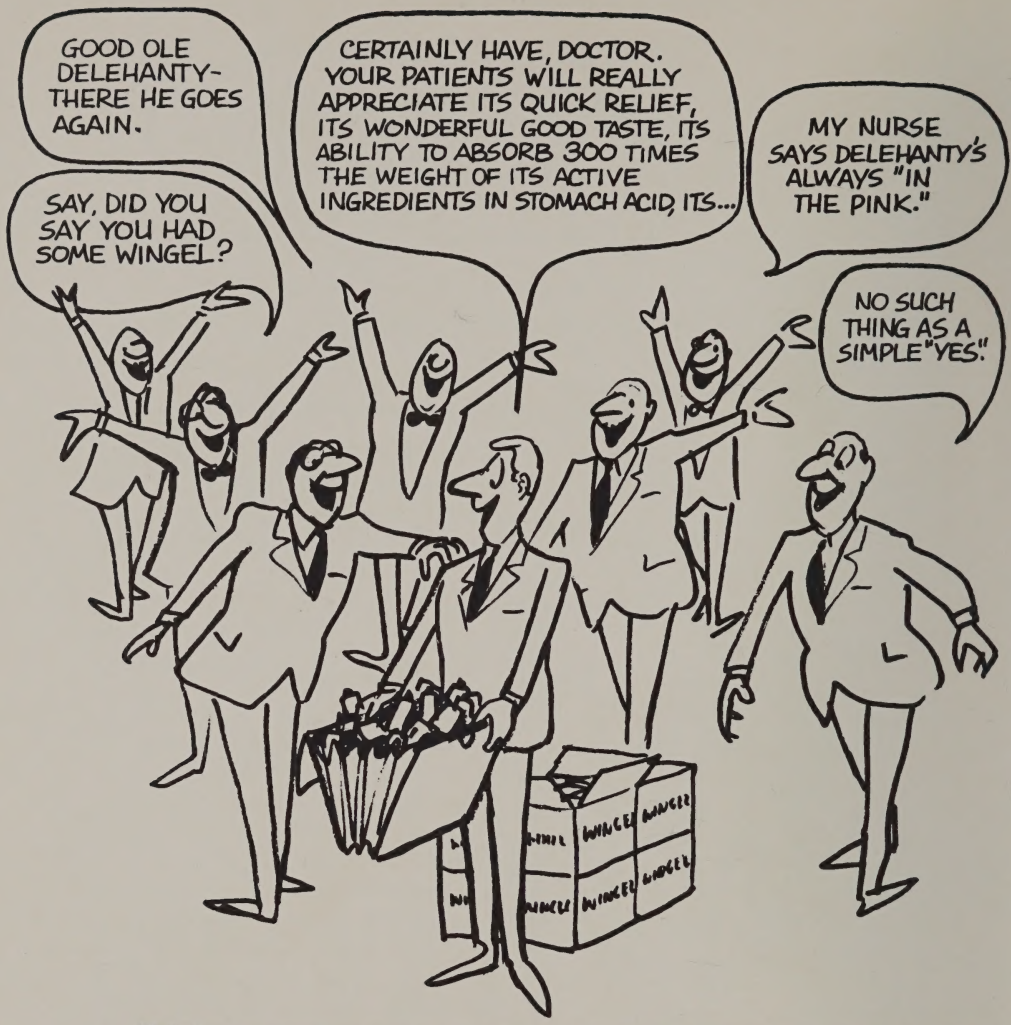

WINGEL IS DELEHANTY'S CUP OF TEA, ALL RIGHT, BUT I'M INTERESTED IN THE SAMPLES.
I LIKE WINGEL BECAUSE IT WORKS, BUT DELEHANTY CONFUSES ME WITH THE FACTS.
I DON'T KNOW WHY I'VE BEEN DELEGATED TO TELL HIM THE MEETING IS CANCELLED. I LIKE THE FELLOW.
CAN'T FIGURE IT OUT. I BROUGHT ALL THIS WINGEL AND NO ONE'S HERE. WHAT AM I GOING TO DO WITH ALL THIS ACID-DEVOURING LIQUID AND ALL THESE RELIEF-GIVING, NON-GRITTY TABLETS I REQUISITIONED JUST FOR THIS MEETING? SUCH A SHAME THEY CAN'T SEE FOR THEMSELVES HOW WINGEL IS THE MIDDLE-OF-THE-ROAD ANTACID- DOESN'T TEND TO SWING TOWARD DIARRHEA OR CONSTIPATION...
WHAT DO YOU EXPECT FROM DELEHANTY? THAT'S THE VERY DISTINCTIVE COLOR OF WINGEL. SETS IT APART FROM ALL OTHER ANTACIDS.
ONLY LAST WEEK, DELEHANTY WAS TELLING ME TO "THINK PINK." BUGS ME. CAN'T GET IT OFF MY MIND. THINK PINK... THINK PINK... THINK PINK...
IF ONLY I COULD GET SOME WINGEL, SANS DELEHANTY, I'D BE HAPPY.
WELL, IF I'M CAUGHT, I CAN ALWAYS CLAIM I WAS DOING PUSH-UPS.
THAT'S EASY. JUST DO LIKE I DID-FILL OUT AND RETURN THIS CARD FOR A GENEROUS SUPPLY OF BOTH LIQUID AND NON-GRITTY TABLETS.
Modell

Dr. _____

Address _____

City _____

State _____ Zip Code _____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SAY, DID YOU SAY YOU HAD SOME WINGEL?
CERTAINLY HAVE, DOCTOR. YOUR PATIENTS WILL REALLY APPRECIATE ITS QUICK RELIEF, ITS WONDERFUL GOOD TASTE, ITS ABILITY TO ABSORB 300 TIMES THE WEIGHT OF ITS ACTIVE INGREDIENTS IN STOMACH ACID, ITS...
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UNISEX?

Dr. Turner's tribute in the October *Hippocrat* to the dedicated ladies of the Hampden District Auxiliary was not only greatly deserved, but also heartening and reassuring to all of us to know that there are still women who are more interested in co-operative endeavor and doing for others and less in self-aggrandisement and exhibitionism. His closing quip – "May the Women's Liberation Movement leave this force for good deeds undisturbed" – served to stimulate some psychological exploring in my psychiatrically oriented thinking regarding the current and possible future effects of some of these movements for women's liberation upon society in general and children in particular.

THE LIB

These are parlous times, with social crises of all kinds on all sides – international crises, the crises between blacks and whites, the crises between youth and "the establishment" and last but not least, a crisis in the making in which some women are protesting their lack of freedom and other presumed deprivations too numerous and nebulous to consider at the moment.

It is this last situation I am particularly concerned with, both because of some of its overall effects and also because of the conspicuous psychiatric symptoms revealed in much of the protestive behavior.

For the past two or more years we have been reading and hearing much about the "Feminist Movement", represented by different organizations, each with its own title and all professing one goal; namely, liberation of women. Regrettably, descriptions and pictures of these organizations appearing in newspapers and magazines have been less than edifying; in fact, some of the material has appeared to be a structured attempt on the part of the publisher to present the movement as a kind of burlesque depicting disturbed and inadequate females in their struggle for recognition.

In a widely circulated pictorial publication there appeared a series of pictures of one of the primary activists in one of these organizations. The photographs were large and startling, and the young woman was portrayed as an unattractive, disheveled, hostile personality, repudiating males for their alleged oppression and utilizing extreme profanities and obscenities with which to achieve her end. The article described her as a brilliant but defiant iconoclast of the type we could well do without in today's

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turmoil. To the psychiatrist she appeared as a person who from an early period had been subjected to failure and unhappiness; she had been severely traumatized, and was now retaliating for her hurts by loudly denouncing men for their responsibility in her plight and vowing vengeance. In short, she appeared to be an emotionally ill person, quite in need of therapy, and ill suited in her role as a leader and example for youth.

In another equally well-circulated magazine was a presentation of "Women Liberationists" depicted as a swarming group of young female protestors, poorly clad, and slovenly attired, marching down Fifth Avenue, demanding child-care centers, free child care, free abortions, and other professed rights. Although the caption designated them as young women, the photograph necessitated close scrutiny in order to ascertain their real sex since this was somewhat blurred by their style of dress.

This new "feminism" can be likened to an emerging neurotic syndrome, coming as it does from a deeper and more significant underlying cause that has become obscured and distorted by a process of rationalization and projection. The protesting female, although she contends she is justifiably protesting external cultural circumstances (foremost of which she claims is masculine injustice) belies this by her vehemence, poor emotional balance, and destructive tactics, all of which point toward an emotional disorder that cannot be completely explained by her alleged lack of opportunity.

UNISEX

Time magazine, in its October 12th issue, under the heading of "Killing a Culture", made the following comment regarding the Liberationist Movement: "To many Women Liberationists, masculinity and feminity are outmoded sexist concepts and the current blurring of sex roles is a welcome development." In opposition to this, anthropologists for many years have been predicting that, when the blending of the sexes occured to the point where one could not distinguish between male and female, it was the beginning of the end of a civilization. Dr. Charles Winick, Professor of Anthropology at the City University of New York, views this "unisex" as having ominous connotations for the future. He cited several instances of terminated cultures in which there existed sexual ambiguity and referred specifically to the fall of Rome.

Dr. Winick stated: "It matters little how masculinity and femininity are defined as long as they are defined. Just about every combination of male and female role relationship can be effective except one in which the roles are blurred." He referred to multiple examples of blended sexes – men with long hair, perfume, and effeminate attire; women with pants, masculine gait and general alteration of demeanor, drinking

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6:30 P.M.—Dinner
8:00 P.M.—Formal Lecture

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Interchanging of sexual characteristics, blending of sexes, blurring of sexual identification (call it what you will) does not augur well sociologically or psychologically. Sexual identification at an early age is a vital step in the healthy mental development of a child, and lack of it may be the cause of a later maladjustment.

Lucy Komisar, in her article entitled "The New Feminism" in the *Saturday Review,* states: "The feminist answer is to throw out the whole simplistic division of human characteristics into masculine and feminine, and to insist that there are no real differences between men and women other than those enforced by culture. The elimination of rigid sex role definitions would liberate everyone, and that is the goal of the Women's Liberation Movement."

A SECOND LOOK

As one reads the material published by members of some of these different "Women's Libs", one is impressed not only with the unrealistic philosophy of the movement but with the clearly defined signs of emotional illness involved. The protestations, the professed struggle, the acknowledged inability to establish identity, the cynicism, and the bitterness expressed toward society in general and men in particular would appear to be symptomatic of neurotic maladjustment.

Our culture has always been patriarchal and perhaps it should continue to be (within limits) in order to maintain itself. In spite of the patriarchal supremacy, there are endless excellent opportunities for stable capable women. They are, however, going to have to "grow up" and cease being defensive about discrimination; if they start looking for it, they undoubtedly will find it. One might conjecture, either correctly or incorrectly, that many of our protestors are nonachievers, self-seekers, and consequently unhappy.

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Women have progressed immeasurably in the past fifty years. They have achieved rights and freedom and status undreamed of in the previous century. One needs only to refer to the expenditure of monies to appreciate the power of women today. They have reached the level where they no longer need to feel subordinated to or oppressed by the male. One would wish that some of the loudly protesting women might realize these facts and redirect their energies toward building up a more stable pattern of togetherness and cooperation.

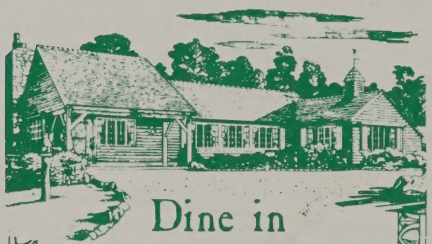
Dr. Mary Calderone has so aptly said: "For women to strike out at men at this time is not only unwise and counterproductive but inhumane and self-defeating. Hostility and vengefulness of women against men is never what is needed at any moment in history but most especially in this one."

One cannot help but ask: Is all this feminine protest symptomatic of a disintegrating society? If so, it behooves us to alight from the merry-go-round and search for a deeper understanding of it all, and subsequently attempt to devise ways and means of correcting it.

To recapitulate, it is refreshing and heartening to know that there are still those women who can forego their own drives for power and recognition to give assistance to a discipline that is predominantly composed of males (medicine). Their willing and gracious participation stems from their awareness of a need that they can fulfill regardless of compensation.

Congratulations and best wishes to our loyal and indispensable Auxiliary members for continued success in their untiring efforts in our behalf.

Cooper



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HIGHLIGHTS OF THE NOVEMBER EXECUTIVE COMMITTEE MEETING

The November meeting of the Executive Committee was held on Tuesday evening, November 17, 1970 in the Conference Room of the HDMS. Present were Drs. Turner, Bandeian, Zacarian, Sullivan, Gilchriest, Kelly, Moore, Mozden, Tarantino (President of Hampshire District) and Mrs. Purdy.

The minutes of the October meeting were read by Dr. Zacarian and approved as read.

Dr. Bandeian, Chairman of the Interhospital and Community Health Planning Committee gave a report of his last meeting which was attended by Mr. James Martin, the local representative of Tri-State Regional Medical Program. Dr. Michael Soper and Dr. Stephen Goldfinger from the Massachusetts General Health Center had attended a meeting of the Committee and spoke about the Medics Program or better known as Physician Assistants. The Committee discussed this program with various pros and cons being brought up. A motion was made to the effect that Dr. Bandeian's committee continue to investigate this Physician Assistant Program.

OLD BUSINESS

Mrs. Purdy gave a report of the telephone listing changes as passed at the October meeting. She has contacted several people connected with the Telephone Company and hopefully the orders given will be carried out as requested. A new unlisted telephone has been installed to be used only by the physicians, otherwise known as the "HOT LINE".

A letter was read from the Medical Society County of New York in answer to HDMS's recent letter criticizing the correspondence being sent to local physicians advertising abortion services in New York. The Judicial Council of the American Medical Association has stated that it, "in the strongest terms possible, condemns the commercialism of the medical procedure of abortion." The hospital involved in New York City has been so informed by the Medical Society County of New York.

NEW BUSINESS

Since Dr. Wesley Hall, Vice President and President Elect of the AMA, has had to cancel his appointment to attend the February HDMS Meeting, a discussion was held as to who should be invited to speak. Several suggestions were made and the Committee will decide after some contacts have been made.

The American International Travel Service had contacted the office about sponsoring a trip to Majorca in March or April. The Committee voted this down.

Dr. Tarantino, President of Hampshire District Medical Society, was asked for any comments he wished to make. He expressed his thanks to the HDMS for cooperating with his society. Hampshire is establishing a speakers bureau and some of the movies from HDMS have been shown in Northampton. He expressed some ideas on utilization review between hospitals.

The meeting was adjourned at 10:00 P.M.

The Grievance Committee met and heard four cases.

The meeting was adjourned at 10:45 P.M.

HDMS DECEMBER MEETING HIGHLIGHTS

Dignitaries Present, L. to R.: Victor Panitch, M.D., Pres. SAM; Lamar Soutter, M.D., Pres. MMS; John W. Turner, M.D., Pres. HDMS; and Carl Johnson, M.D., Hartford County Medical Association

The December meeting of the HDMS was held at the Storrowton Tavern, West Springfield, on December 8, 1970, in conjunction with the Springfield Academy of Medicine and the Hampshire District Medical Society. In attendance were some 192 physicians, the largest attendance in some time.

The HDMS's business meeting was called to order by President John W. Turner at 6:05 P.M. After the minutes of the last meeting were accepted as read, Dr. Harry N. Memery, Chairman of the Bylaws Committee, proposed a bylaw amendment whereby the Interhospital and Community Health Planning Committee would be made a standing committee of the HDMS (see *The Hampden Hippocrat,* November 1970 issue, Page 29). A question was raised as to the composition of this committee, since a designee from a particular hospital might not be a member of the HDMS. It was pointed out that this would not necessarily be a grave matter; past experience of the Disaster Medical Care Committee, which has non-members thereon, has not yielded any problems. The proposed bylaw amendment was passed without any changes.

Under old business, Dr. Allen Johnson's suggestion that the Treasurer collect the cost of the meal from each Senior Fellow at the time of attendance at the District meeting was briefly discussed and left up to each respective Senior Fellow to voluntarily pay for his dinner.

After a brief recess for a social hour and dinner, the meeting was reconvened with Dr. William Beachman, Hampden's representative on the MMS's Committee on Tax Supported Medical Care, rendering the following report:

"A petition for review of action of the Rate Setting Commission and for declaratory relief was filed in the Superior Court for Suffolk County on November 17, 1970 on behalf of Drs. Louis F. Alfano and Thomas A. Flaherty and all other physicians providing services

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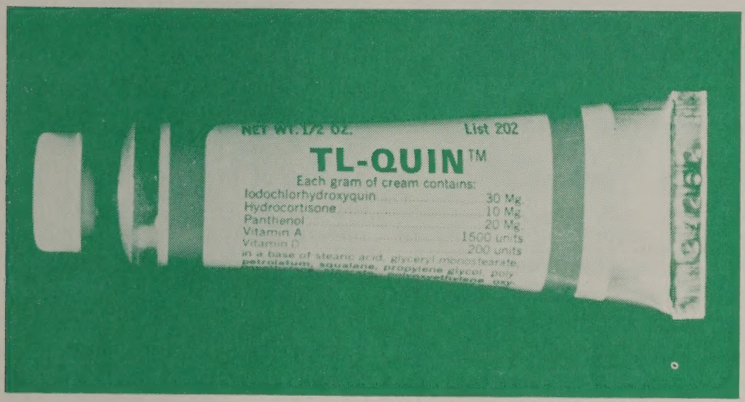

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L. to R.: Joseph C. Tarantino, M.D., Pres. Hampshire DMS; Victor Pantich, M.D.

to Medicaid beneficiaries in Massachusetts.

The petition requests the Court to order the Rate Setting Commission to hold a public hearing and to establish rates of payment for Medicaid patients that will be adequate, fair, reasonable, non-discriminatory and non-confiscatory.

The Rate Setting Commission was established by the Massachusetts legislature in 1968 and it has the responsibility of establishing rates for services rendered by physicians to Medicaid patients 'at least as often as annually.'

Despite this requirement, the Commission has neither held hearings nor established rates for physicians providing Medicaid services since the organization of the Commission in 1968.

Physicians' services to Medicaid patients are now being reimbursed on the basis of a fee schedule originally devised in 1950 and modified in 1957. The level of fees now being paid by the Department of Public Welfare fails even to reflect the substantial increases in the cost of living over a period of many years. The fees are far below current prevailing fees for physicians; and they are not 'fair and reasonable' as they are required to be by law."

The said court action was initiated because there seems to be some apparent "stalling" on the part of the Rate Setting Commission to establish equitable payments for physician services to Medicaid patients inspite of all of MMS's endeavors including the Arthur D. Little, Co., studies and report. As events develop, the Society's membership will be apprised of same.

As a fitting climax to the evening, Dr. Lamar Soutter, President of the MMS and Dean of the UM School of Medicine presented an interesting talk covering a variety of problems confronting physicians today. Of course, the high cost of medical care is the most outstanding with many factors contributing thereto and with most not subject to control by physicians. He also spoke of the difficulty of procuring malpractice insurance to say nothing of the cost thereof. A plea was made for joint planning to avoid underutilization and duplication of expensive medical care facilities. In conclusion and upon question, Dr. Soutter gave a progress report on the development of the UM School of Medicine, which seems at long last becoming operational.

There being no further business, the meeting was adjourned at 9:30 P.M.

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Dr. Stebbins spoke at the Holyoke Public Schools' Learning Disabilities Institute presenting a pediatrician's viewpoint.

Dr. Zadworny spoke to the Women's Division of the Chamber of Commerce on "VD in Our Community."

CONGRATULATIONS TO:

New Fellows inducted as members of the American College of Surgeons from Hampden, Drs. Lorne Smith, D. D. Dasco, Robert S. Mandell and Frank J. Sterba;

Dr. Donald Hayes, elected as Governor of the American College of Surgeons;

To Drs. Coen and Mandell, who were recently honored by Temple Beth El.

To Dr. Gene Black of Holyoke who was recipient of the 1970 Dwight Award.

Dr. Hayes was moderator of an all day symposium on "New Approaches to Health Care Delivery" at the Clinical Meeting of the AMA in Boston. He also was Chairman of Reference Committee E at the meeting.

Dr. Niemiro gave a talk in Bermuda to the Northeastern Proctologic Conference.

Dr. Weisman spoke to the Probus Club on "Reducing Your Risk of Heart Attack."

Dr. Kisiel demonstrated cast applications at the Special Exhibit on Fractures at the Clinical Meeting of the AMA in Boston.

Dr. Hough gave the Invocation at the opening sessions of the Clinical Meeting of the AMA in Boston.

Mrs. Purdy was a hostess at the party given by the American Association of Medical Society Executives at Anthony's Pier 4 in the Peter Stuyvesant.

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CORRESPONDENCE SCHOLARSHIPS AVAILABLE

To the Editor:

The Massachusetts Board of Higher Education announces 1971-72 applications for the Massachusetts State Scholarship programs administered by the Board are now available from secondary schools, colleges, medical, dental, and nursing schools in Massachusetts. The Board will award approximately $4,000,000 under the State Scholarship programs for 1971-72.

The application deadline for 1971 entering college freshmen and first year nursing students is December 15, 1970. High School seniors are urged to obtain applications from their Guidance Officers or other appropriate officials. Applications for students already enrolled in post-secondary programs, and for all medical and dental students must be submitted by April 1, 1971.

State scholarships are available for all undergraduate fields, collegiate and hospital nursing programs, and for medical and dental programs. Financial need and residency are the necessary qualifications for these awards. Massachusetts Honor scholarships, based solely on academic ability, are available for all Massachusetts four year public colleges; scholarships are also available for children of deceased members of fire and police departments. Applications are now available in the guidance offices of all Massachusetts secondary schools, the financial aid offices in colleges, medical and dental schools; and in the offices of directors of nursing schools of nursing. Students enrolled in out-of-state institutions should contact the Scholarship Office, Board of Higher Education, 182 Tremont Street, Boston 02111 to obtain application forms.

The Board of Higher Education has awarded approximately 6,000 State scholarships for the 1970-71 academic year, and expects to award approximately the same number for 1971-72. Students who are in need of financial aid to continue their education should obtain State Scholarship applications from their guidance counselors or financial aid officers.

For further information contact Miss Catherine H. Gerhart, Assistant to the Director of Academic Planning and Coordinator for Student Assistance at 727-5367.

Edward C. Moore, Chancellor
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13 Aids in Avoiding Lawsuits

In a recent article in *Resident and Staff Physician,* (June, 1970), Gene Balliett, president of a management consultant firm, presented thirteen points to aid in avoiding a malpractice suit. Once professional liability insurance has been bought and the policy carefully read, the following steps are recommended when problems arise with a case:

1. ALERT YOUR INSURER. Notify him as soon as an accident occurs, instead of waiting until you receive notice of an impending lawsuit.

2. KEEP YOUR INSURANCE COVERAGE TO YOURSELF. Do not invite a malpractice suit by announcing to others the extent of your insurance coverage.

3. ADMIT AN HONEST MISTAKE – BUT NOT LEGAL LIABILITY. Admitting an honest mistake is not the same as assuming liability. A court of law is responsible for determining liability.

4. WHEN YOU DO ERR, AVOID THE RISK OF MAKING AN EVEN BIGGER ERROR – THAT OF TRYING TO COVER UP. Even after making an error, continue to practice good medicine. A court may forgive an honest mistake, but usually will not rule favorably if a mistake is compounded by an effort to cover it up.

For guidance with a specific case, the best initial source of advice is your professional liability insurer:

5. REFER THE PLAINTIFF'S ATTORNEY TO YOUR OWN. Allow the lawyers to talk together, with the physician staying out of the conversation as much as possible.

6. IF A CASE DOESN'T GO QUITE RIGHT, THINK TWICE ABOUT TURNING THE PATIENT'S ACCOUNT OVER FOR COLLECTION. Employing a collection agency often is the action which finally pushes a patient into bringing charges against a physician.

7. LEARN TO RECOGNIZE A SUIT-PRONE PATIENT. Special care should be taken with patients who show an over-concern with money, unusually pointed criticism of one or more previous doctors, suspicion, and an unrealistic expectation of good results.

8. PROCEED ONLY WITH A PATIENT'S INFORMED CONSENT. A physician cannot legally proceed unless informed consent is obtained from the patient.

9. PRACTICE WITHIN THE LIMITS OF YOUR COMPETENCE. If a physician presents himself as a specialist, he must practice as a competent specialist.

10. BE SLOW TO GUARANTEE A GOOD RESULT. If care is taken while discussing a case or procedure with a patient, there is less chance of being held for breach of oral contract.

11. KEEP GOOD RECORDS. Extensive, accurate records are a necessity if a case is brought to court.

12. SEE A CASE THROUGH ONCE YOU START. Once a physician begins to see a patient, he cannot abandon him without being held responsible for him.

13. HEAD OFF ASSISTANT'S ERRORS. The physician is responsible for anything done by anyone who works for him.

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